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ABSTRACT

This final report discusses the activities and outcomes of an interdisciplinary graduate program designed to prepare already licensed or certified physical therapists and occupational therapists for the full inclusion of students with disabilities in educational settings and for the full participation of infants, toddlers, and young children in natural settings. The program resulted in: (1) the certification of 25 physical therapists and 10 occupational therapists; (2) the development and evaluation of a related services certificate model; (3) the completion of a school-based practicum by 19 students, during which the students created individualized action plans and were paired with a professional mentor with complementary expertise; (4) the development and evaluation of the early intervention certificate model focused on providing pediatric therapy intervention in natural environments; and (5) a workshop for families interested in serving as mentors for the practicums, and the pairing of these mentors with 17 therapists to develop an understanding of the ways early intervention therapists can assist families and children in accessing and using community resources. Charts illustrating the certificate programs for school-based services and for early intervention services are provided, along with an article describing the early intervention certificate program ("Physical Therapist Education for Service in Early Intervention" from Infants and Young Children, Aspen Publishers; April 2000; 12(4): 63-76). (CR)

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Specialist Certificate Program: Preparing Professionals To Provide Services in Natural Environments and Inclusive Settings: Final Report

Project Directors: Lisa Ann Chiarello and Phiippa Campbell

January 1998-December 31, 2001

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Special Education – Personnel Development and Parent Training
Grant #: H029G970066-99
Specialist Certificate Program: Preparing Professionals to Provide Services in Natural Environments and Inclusive Settings
Project Directors: Lisa Ann Chiarello, PT, PhD, PCS and Phiippa Campbell, OTR/L, PhD, FAOTA

Final Performance Report

Project Summary

The Specialist Certificate Program was designed as an interdisciplinary graduate program with two distinct Certificate components: (1) Related Services: to prepare already licensed or certified physical therapists and occupational therapists to demonstrate competencies that promote the full inclusion of students with disabilities in educational settings; and (2) Early Intervention: to prepare already licensed or certified physical therapists, occupational therapists, and other early intervention providers to demonstrate competencies to promote the full participation of infants, toddlers, and young children in natural environments.

A total of at least 30 graduates, 15 in each Certificate component, were to complete one of two distinct 18-credit programs. The programs each included 5 courses and a practicum experience with a mentor, that were to result in: (a) acquisition of specifically delineated competencies for related services or for early intervention professionals; (b) attainment of a graduate Certificate in Related Services or Early Intervention, granted by MCP Hahnemann University; and for physical and occupational therapists, acquisition of foundation requirements toward application for Pediatric Specialty Certification granted by AOTA (for occupational therapists) and by APTA (for physical therapists). Trainees were to be employed in educational or early intervention settings and were to complete Certificate requirements on a part-time basis, receiving tuition reimbursement for successful completion of two to three courses annually.

Project Status

The following report reflects the activities that have been completed from the start of the program January 1998 through December 31, 2001, towards the accomplishment of program objectives, with an emphasis on activities from April 1, 1999 to December 31, 2001.

Objective 1: Recruit and select 15 trainees for each of the two new Certificate programs (pgs. 35 & 37 in grant application)

In the summer of 1998, 30 students were awarded full funding for the program (16 in the related-services component and 14 in the early intervention component). In the summer of 1999, an additional 17 students (10 in related services and 7 in early intervention) were enrolled into the program with partial funding. In total, 35 therapists (19 in related services and 16 in early intervention), 25 physical therapists and 10 occupational therapists, have completed the program and earned a certificate. **Table 1** highlights the diversity of the students.

Table 1:
Certificate Students

Component	Total completed program / enrolled	Fully funded	Partial funded	PTs	OTs	Educator	Under 10 years pediatric experience	Over 10 years pediatric experience
Related Services	19 / 26	13 /16	6 / 10	14 / 15	5 / 11		6 / 11	13 / 15
Early Intervention	16 / 21	10 / 14	6 / 7	12 / 13	4 / 7	0 / 1	9 / 12	7 / 9
Total	35 / 47	23 / 30	12/ 17	26 / 28	9 / 18	0 / 1	15 / 23	20 / 24

The coordinators of the program, Lisa Chiarello, PT, PhD, PCS, and Suzanne Milbourne, M.S., OTR/L met on a routine basis throughout the program to oversee activities and status. The Pediatric Program Advisory Board met twice a year to provide recommendations and feedback regarding program activities to better reflect the needs of the community.

Objective 2: Develop and evaluate the Related Services Certificate Model (pgs. 35 & 37 in grant application)

Throughout the program all but one of the courses (Pediatric Seminar I - Working in Inclusive Educational Environments, Developmental Assessment, Motor Control Issues for Therapists, Motor Learning and Development, Musculoskeletal Therapy in Pediatrics, and School-Based Practicum) were offered at least two times to enable students the opportunity to enroll in all the courses. Pediatric Seminar II, Evidence-Based Practice, and the School-based Practicum have not been previously reported and will be described below.

The second of a two series seminar, Pediatric Seminar II - Selected Topics in Pediatric Therapy and Management Strategies for Working in Inclusive Educational Environments, was conducted in the summer of 1999. Sixteen students took the course and successfully achieved the requirements. In the course students completed assignments related to developing educationally relevant IEP goals and outcomes and the development of individualized intervention plans. Students worked in small groups and were assigned a "client". Video case stories were reviewed weekly and students discussed and reflected upon a structured set of guiding questions. Small groups presented the case story that included a client description, ideas for assessment, generation of a vision, information from the family, the suggested IEP, creative interventions, and methods of documentation and follow-up. Secondly, individual students wrote a case story based on the same client and submitted the case story to a professional journal, one of which was subsequently published Students in the entry-level MS program in OT with a pediatric concentration also participated in the seminar. The students in the certificate program indicated that the case-based format was an effective approach to learning skills directly applicable to clinical practice in a school setting. However, they noted that the integration of entry-level students with post professional students limited the depth and breadth of material that could be covered.

In the fall of 2000, 4 students who had not yet enrolled in the Motor Control didactic course had the opportunity to enroll in Applications of Motor Development, Learning, and

Control Theory to Clinical Practice due to department curriculum restructuring. This course focused on evidence-based practice. All four students successfully completed the course. The course objective was for students to demonstrate the ability to evaluate theories and models of intervention; analyze evidence for interventions; critique the use of clinical pathways, consensus documents, and clinical guidelines in practice; make evidence based decisions on methods of service delivery, frequency, and duration of treatment; critique methods of evaluating therapy interventions; apply evidence on prognosis and determinants of intervention outcomes to decision making; and identify and analyze the theories, rational, and assumptions that influence clinical reasoning. For assignments, students were required to complete literature searches and present evidence for therapy intervention and determinants of outcomes; they developed a protocol for documentation of goals and outcomes for therapy; and design a model for therapy intervention which included multiple forms of evidence, has meaning to practice, and reflects clinical reasoning practice. Based on student evaluation of the class all four students strongly agreed or agreed that the required readings were worthwhile, the expectations were high but reasonable, and they gained a good understanding of the course concepts. Student comments in response to "what were positive aspects of the course" included, "the clinical relevance of the course and the flexibility given to each individual to make their research pertinent to both interest and practice situations"; "the process and the guidance that came from the way the assignments were arranged – each building upon and lending itself to the final paper."

Nineteen students successfully completed the School-Based practicum. During the practicum students created individualized action plans based on their own interest and self identified area to improve professional competency. Based on individual action plans each student was paired with a professional mentor with complementary expertise. The purpose of the practicum focused on students enhancing their competency in issues related to providing services in inclusive environments through the accomplishment of individualized objectives. Therapists had the opportunity to nominate mentors, identify an individual project and project outcomes, maintain a reflective journal and activity log, present the results of the project, and evaluate the practicum experience. Each student collaborated with their mentor (minimum of 45 contact hours) who provided guidance, reflection, and feedback on the development and in some cases the implementation of the project. **Table 2** outlines the content of selected practicum projects. As a result of the practicum in the spring of 01 each student presented a summary of their practicum project and results to their classmates and instructors. Presentations focused on the outcomes and potential impact that the project had on various school districts/individual schools in which the students were employed.

Table 2:
School-based Practicum Projects

Content	Example
Program Development Projects	Regional Efficiency Development Incentive Program – student submitted an grant application to develop a county-wide Integrated Preschool Program.
Staff Development	Development of supervisory guidelines in agreement with current state codes, IDEA, and professional codes of ethics. Design and implementation of a staff inservice focused on switching from a medical to an educational model of intervention.
Best Practice	Case study to improve effectiveness in providing integrated support. Development of a guide, Best Practice Standards: a Guide to Writing Meaningful and Measurable Objectives. Facilitation of an integrated and family-responsive IEP process in one school district.
Clinical Reasoning	Pilot survey was performed to explore decision making for physical therapy services in New Jersey public schools.

Overall the students and mentors identified that they benefited from the practicum program. **Table 3** summarizes the feedback provided through a written evaluation given to the students at the completion of the practicum. Overall, the majority of students reported having a positive and effective experience in enhancing their competency in issues related to providing services in inclusive environments. On the written evaluation students answered open-ended questions such as "what was the most beneficial aspect of the practicum experience". Fifty percent of the students reported that the relationship with the mentor and the fact that the practicum directly related to their work environment were highly beneficial. On the other hand the most challenging aspect of the practicum was scheduling time with the mentor. During advisory sessions students verbally reported improve clinical skills, overall satisfaction, and an interest in 50% of the students intent to continue the relationship with their mentor. Mentors also completed a written evaluation at completion of the practicum providing information about their experience as a mentor. Mentor feedback was solicited via a mailed, anonymous survey evaluation. **Table 4** summarizes the feedback from the mentors. Fifty-six percent of the mentors rated their overall quality of the experience as excellent, forty-four percent as good. Fifty percent were very satisfied and fifty percent were mostly satisfied. Ninety-four percent of the mentors indicated that the experience was positive for their own professional development.

Table 3:
Student Practicum Survey

My mentor was available for guidance throughout the practicum	87% agree or strongly agree
I was able to achieve my individualized objective through the mentorship experience and project.	100% agree or strongly agree
Has this experience helped to improve your clinical skills in inclusive environments?	100% yes
Based on your experience, would you like to share your experience by becoming a mentor?	43% yes 43% undecided

Table 4:
Mentor Survey – Sample responses

What was most the most beneficial aspect of the practicum experience?	Collaboration with mentee Opportunity to "brainstorm" Broaden my connection with other therapists
What was the most difficult aspect of the practicum experience?	Scheduling time to communicate/meet Recognition of being the "expert" Challenge of implementation of ideas into practice
Please comment on specific suggestions to improve the practicum experience.	Implement group projects (2-4 students with one mentor) Facilitate communication between and among mentors Provide additional resources for mentors
Would you like to continue the mentor relationship?	81% responded YES

Interdisciplinary competencies were developed for the students in our program to identify their strengths and to guide their graduate study to meet the competencies that they had not yet achieved. The advisory board and steering committee reviewed drafts and final suggestions/recommendations were adopted and incorporated into the final document. As a result of feedback, the competency area Research was pulled out as a separate competency area and relative competencies and behavioral indicators were developed for each major competency area. Refer to **Appendix A** for the final version of School-Based competencies.

A Pediatric Newsletter has been distributed three times to over 1200 pediatric physical and occupational therapists in the Delaware Valley region. The Pennsylvania Interagency Coordinating Council on a quarterly basis now publishes the newsletter, Pediatric Therapy Newsletter. The newsletter will continue to reach the targeted population when the activities of this grant project end. The newsletter contains information regarding continuing education opportunities, recent legislation and standards, and discussion of recently published research and its application to pediatric practice.

Objective 3: Develop and Evaluate the Early Intervention Certificate Model (pgs. 35 & 38 in grant application)

Throughout the program all courses (Pediatric Seminar I and II: Early Intervention in Natural Environments, Developmental Assessment, Motor Control Issues for Therapists, Motor Learning and Development, Musculoskeletal Therapy in Pediatrics, and Family Practicum) were offered at least two times to enable students the opportunity to enroll in all the courses. Pediatric Seminar II: Early Intervention in Natural Environments and the Family Practicum will be highlighted for they have not been previously reported.

Pediatric Seminar II expanded the foundational information learned in the first seminar course. The seminar focused on providing pediatric therapy intervention within the context of activities and routines that occur in environments that are natural for infants and young children. Students had to develop, provide, and evaluate the impact of therapeutic interventions within the context of naturally occurring activities and routines in home and community settings, identify factors that facilitate and inhibit provision of intervention within this context, and use problem-solving strategies to minimize the impact of system and program barriers to provision of services within natural settings. All sixteen students successfully completed the course requirements that resulted in students applying course information directly to early intervention service plans for children and families they were serving. The students positively rated the course for its direct application to their practice.

In the spring of 1999, a workshop was held for families interested in serving as mentors for the practicums. The workshop was entitled "Families and Therapists Working Together for a Better Tomorrow". Four families attended the workshop. The workshop's agenda included discussing: experiences families have had with therapists, what is mentoring, benefits to being a mentor, communicating with others, how to solve problems, building relationships, sharing stories, mentor's roles, responsibilities, and resources for the practicum experience. With attendance at the workshop being difficult for some families, a subsequent orientation meeting was held with six family mentors and the therapists who they would be matched with. The workshop topics were covered at the orientation and the family mentor and therapist had the opportunity to get to meet each other. Additional orientation sessions for the other family mentors were completed through phone conferences. During the family practicums, 17 therapists spent 45 hours with a family mentor to develop an understanding of the ways in which early intervention therapists can best assist families and children to access and use a wide variety of community resources. Therapists had the opportunity to observe family daily routines to experience the complexity of issues and concerns facing families receiving early intervention. Each therapist collaborated with their family mentor on developing a resource for families and therapists in early intervention. **Table 5** outlines the content of the practicum projects. These resources have been disseminated to all the families and therapists who participated in the program. In addition, the families and therapists have been asked to share these resources with their community early intervention agencies so that others may benefit from these projects. A copy of the resources has also been provided to the State of Pennsylvania's Early Intervention Technical Assistance Program.

Table 5:
Family Practicum Projects

Family Practicum Resources
• Preschool / Daycare <> Home Communication Form
• Interview Process for Reviewing Prospective Preschools / Daycares
• Preschool Screening Form
• Community Resource Manual
• Development of a Family Support Group
• Promoting Mobility in Daily Routines
• Websites for Children and their Families
• Assistive Technology and Adaptive Equipment for Children
• Computer Accessories
• How to Access State Agencies
• Promoting Family Involvement in the Local Interagency Coordinating Council
• Tips for Organizing a Playroom
• Therapy in Everyday Activities
• Support Groups and Agencies for Families with Children with Developmental Delays
• Early Intervention for Children in Foster Care
• Early Intervention: General Information
• Medical Assistance
• Medical Specialists
• Intermediate Unit Contacts for Preschool-age Services
• Recreation Programs
• Advocacy Groups
• Publications and Newsletters
• Respite Care
• Funding Sources
• Transportation

Overall the families and therapists benefited from the practicum program. Eighty-six percent of the family mentors rated the overall mentorship experience as excellent and 14% rated it as fair. The therapists were more variable in their overall rating: 25% excellent, 50% good, 19% fair, and 6% poor. Eighty-five percent of the family mentors indicated that the experience was positive for their personal and professional growth and development. Seventy-five percent of the therapists indicated that the mentorship experience helped them to improve their clinical practice. Overall 93% of the families were very to mostly satisfied with the mentorship experience and only 7% were indifferent or mildly satisfied. Seventy-five percent of the therapists were very to mostly satisfied with the mentorship experience, 19% were only indifferent or mildly satisfied, and 6% were dissatisfied. Based on their experiences 86% of the family mentors indicated an interest as serving as a mentor in the future. From the families' perspective the most beneficial aspect of the practicum experience was varied.. Some of the more common responses included that they felt they gained knowledge and skills, learned about resources, shared experience with someone who cared, learned about the therapist's role in early intervention, and took action by developing a resource for other families and therapists. From

the therapists' perspective the most beneficial aspect of the practicum experience was developing a better understanding of family life and daily routines. From both the families' and therapists' perspectives the most challenging aspect of the practicum experience was scheduling the visitations.

Competencies for physical and occupational therapists in early intervention have been developed for the certificate program (See **Table 6** for Content Areas and Sample Competencies and **Appendix B** for full document). The final document was reviewed by MCP Hahnemann University's Post Professional Programs in Pediatric Rehabilitation Sciences Advisory Board and was adopted. The competency document was used by the students in our program to identify their strengths and to guide their graduate study to meet the competencies that they had not yet achieved. The document is a comprehensive listing. It was not expected that all competencies would be achieved through the certificate program. However, the document helped the students with their life long learning to promote quality care for children. For each competencies, behavioral indicators were specified so therapists could evaluate the extent their practices supported their achievement and implementation of the competencies. On the document the student rated each competency as no experience, minimal competency, emerging competency, and achieved. For the competencies that have not been achieved, the student, in consult with their advisory developed an action-learning plan. The student was also expected to indicate the objective documentation that supported the achievement of the competencies.

A poster was presented by Chiarello and Milbourne at the OSEP Personnel Training Conference in September, 1999 on "Pediatric Specialty Certification in Early Intervention and School-Based Services: Competency Based Approach to Professional Development". The poster highlighted the process used in our program to develop the competencies and how the competencies were integrated into the framework of the program's curriculum and evaluation process. The certificate program in early intervention was highlighted in an article in Infants and Young Children on "Physical Therapist Education for Service in Early Intervention" in 2000 by Effgen and Chiarello. The article emphasized the interrelated role of the therapists, families, community, state and local early intervention systems, early intervention seminars, professional content courses, family practicum, program evaluation, and university resources to promote quality service delivery through the therapists' obtainment of competencies in early intervention.

Table 6:
Major Content Areas and Examples of the Early Intervention Competencies

1. Context of therapy in natural settings
    - Knowledge of the central importance of family and is able to provide family-centered services
2. Wellness and prevention
    - Promote public awareness of early intervention services
3. Coordinated care
    - Form a partnership and work collaboratively with other team members, especially the child's family
4. Examination and evaluation
    - Individualize the examination and evaluation for child, team, and family needs
5. Planning
    - Actively participate in the development of the Individualized Family Service Plan
6. Intervention
    - Assist families in accessing services that promote full inclusion of child and family into the community
7. Documentation
    - Evaluate and document the effectiveness of intervention strategies
8. Administration
    - Demonstrate leadership abilities in promoting effective team processes
9. Research
    - Apply knowledge of research to the selection of therapy intervention strategies and service delivery systems in early intervention
10. Professional development
    - Utilize opportunities and resources available to enhance professional knowledge, skills, and attitudes

Objective 4: Carry out the project's evaluation plan. (pgs. 35 & 38 in grant application)

All students in the certificate program received individualized advisory meetings each semester. The majority of meetings were held via phone conferencing or e-mail due to the students' proximity to and limited time on campus. Advisory meetings were intended to guide students as they entered the program in setting up the schedule for courses, discuss course content and application to practice, dialog about the competencies and their self-rating, discuss professional development issues, and to collect feedback on their individual progression and on the progression of the overall program.

Consumer feedback

Program evaluation was conducted using a consumer program evaluation survey. Certificate students submitted names of teachers, therapists (not in the program), administrators, and families who they have practiced with over the course of the past year. A survey was developed and sent to these individuals to evaluate the impact that our program has had on the

community. Twenty-two supervisors, 24 co-workers, 2 recipients of services and 4 others (including case managers) completed the survey for a total of 52. Responses were received from a total of 21 early intervention surveys and 27 related service surveys (4 unidentified). Respondents were asked if they observed any positive changes in a variety of practices. **Table 7** reports a sample of the items and the responses where some or a significant change was observed. In some cases responses respondents indicated that items may not have been observed.

Table 7:
Consumer Feedback

Positive change observed (some or significant)	Early Intervention	School Based
Collaboration with team members including family	19/20 (95%)	20/21(95%)
Consultation practices	15/16 (94%)	22/23 (96%)
Examination and Evaluation	16/19 (84%)	20/21 (95%)
Intervention/Program planning	18/20 (90%)	21/22 (95%)
Documentation	14/17 (82%)	17/19 (89%)

Consumer respondents were also asked to describe a situation where the therapist displayed an innovative approach to therapy. Forty-four of the 52 respondents described an innovative example (the others left this section blank). Selected examples from both the early intervention surveys and the school-based surveys are listed in **Table 8**.

Table 8:
Consumers' examples of an innovative therapy approach displayed by a therapist in the certificate program

Early Intervention Responses	School-based responses
She looks around the room and uses what is already there to provide therapy and challenges.	The therapist devised an approach for a student with full use of only one arm to place his back pack on the back of his chair so that he could maintain his belongings independently.
She now videotapes sessions to help document change.	Incorporating music through small tasks to meet children's needs (ex: jump like a frog and hop on one foot)
Melissa came up with an innovative solution to providing therapy in a small group with parents present when home-based therapy goals had been met.	Utilizing the SFA, Sue wrote a report recommending accommodations that the teacher, CST Director, case manager, nurse, additional teaching staff, and parents all felt was fantastic.
She has made a significant effort to be community based, treating children at malls and playgrounds.	Working through a child's one on one aide to improve his independence and participation.
Shelly really brought the concept of blending family priorities and visions when planning therapy sessions. She was the driving force in our participation in YMCA gym programs for families.	PT carefully and deliberately designs an activity each week to specifically meet the needs of my child and adjusts that activity accordingly.
Has utilized playgrounds as an area for treatment; has utilized swimming pool as an area for treatment.	Karen has graphed and displayed students' outcomes. It has been great to see the results of her efforts and her graphs educate us about her work with our kids.
She takes the time to meet with parents, gives info on the therapy session and discusses concerns they might have.	Mary uses a lot of the classroom environment through her therapy to give the child the most unrestricted and integrated environment that is possible.
She met the child and mother at a local supermarket that has kid carts available. She bought sand weights to slow down the child's shopping cart and they had a session in the store to promote his walking skills.	More routine group treatment. For example in a class there is "Friday AM movie time". During this time the OT worked with PT on positioning. The OT incorporated social skill learning, fine motor, etc.

Therapist End of Program Survey

Thirty-two of the students completed an end of program survey. The top responses for the most important knowledge or skills they gained from the program included: applications to contemporary clinical practice, family-centered care, interaction and networking with other

therapists, developmental assessment, motor control and motor learning, evidence-based practice, and natural environments / inclusion. One hundred percent of the students indicated that the program impacted their skills related to the context of therapy, examination / evaluation, intervention planning, and professional development. Ninety-seven percent also indicated that it impacted their skills related to coordination and intervention and ninety-four percent in documentation. Sixty-three percent rated the overall quality of the program as excellent, thirty-seven percent as good. Fifty-three percent were very satisfied with the program, forty-seven percent mostly satisfied. All the therapists indicated that their expectations and needs were met. Ninety-four percent would recommend the program to a colleague. Seventy-six percent of the students indicated that they would continue their post professional education through a degree program and nine percent would be taking a specialty certification exam in their field. A hundred percent of the students indicated that there was a continued need in the community to offer a program in early intervention and school-based therapy services.

Pre-Post Attitude Surveys

Pre and post attitude surveys of the therapists''s views of practice were collected from both the early intervention and school-based students. The early intervention attitudes were measured using the Measure of Processes of Care for Service Providers (MPOC-SP), MPOC Research Group, McMaster University, Hamilton, Ontario, 1997. School-based therapists completed a survey revised from Effgen & Klepper, 1994. Surveys were completed anonymously by both groups in their first course and at completion of the program. Basis review and analysis of the data are reported here. Further analysis of the survey data will be forthcoming in a peer review publication submission.

Early Intervention student responses

The survey completed by the early intervention therapists posed statements about family centered practices asking for two responses. One, "indicate how much you display the behavior described" (scale of 0 – not applicable to 7 – to a very great extent), and two, "indicate how important the behavior is to you (1- not very important to 5-extremly important)." The purpose of the survey is to understand the actual experiences and perceptions of therapists''s interactions with families to whom they are providing early intervention services. Sample statements are listed below in **Table 9**. Overall, a high majority of responses on the survey indicate positive responses to both indicators at pre and post survey data collection. The range of responses to the first indicator was from 3-to some extent to 7-to a very great extent, indicating that students have a positive self-perception about their own family centered practice behaviors. On the second indicator, how important is the behavior, a very high majority of responses indicate that therapists agree that using family centered practices is between 3-somewhat to a 5-extremely important.

It appears at initial analysis that there are few significant differences between pre and post program surveys in the attitudes of the early intervention therapists. This may be due to the fact that upon application to the program applicants were rated on their potential to be a "leader" in the field based on their experiences and resume. Therefore, these therapists may have come to the program with positive attitudes toward family centered practices. One initial finding

indicates a significant change in therapists' level of familiarity with the concepts and philosophy of family-centered practices. Responses on the pre survey ranged from 2 (to a very small extent) to 7 (very) and on the post the responses ranged from 6 – 7. Also, therapists indicated that their comfort level in using a family centered approach to practice increased from pre to post survey. Pre responses ranged from 3 (to a small extent) to 7 (very). Comparably, post responses ranged from 6 – 7.

Table 9:
Sample Statements from the MPOC-SP

"In the past year... To what extent did you...		
offer parents and children positive feedback or encouragement?	Indicate how much you display the behavior described.	Indicate how important the behavior is to you.
take the time to establish rapport with parents and children?		
look at the needs of the "whole" child instead of just physical or medical needs?"		

School-based student responses

The survey completed by the school-based students posed statements asking for two responses. One, "how the statement reflects the actual practice in your school system", and two, "how you believe the statement should reflect practice in your school." Overall it appears at initial analysis that there are few significant differences in the attitudes of the school-based therapists between pre and post program surveys. This may be due to the fact that upon application to the program applicants were rated on their potential to be a "leader" in the field based on their experiences and resume. Therefore, these therapists may have come to the program with positive attitudes toward best practice. There are however some changes in attitude worth mentioning here in regard to responses about what practice "should look like". A 25% increase was noted in response to the statement each discipline evaluates and reports on the student separately that this is not best practice. On the post surveys there were five items (listed below) where there is between a 6-31% increase in agreement with best practice statements. Examples of the statements where there appears to be significant difference (improved attitude) when comparing pre and post surveys are shown in **Table 10.**

Table 10:
Sample Changes in Attitudes from Pre- to Post Program

Statement	Pre % in agreement (should always happen)	Post % in agreement (should always happen)
Part of an evaluation is done in the classroom or other natural environment	69%	100%
Parent's opinions and concerns are included in the assessment process	88%	100%
Evaluations are discussed in a team meeting to determine the priorities, goals, and objectives	82%	100%
The parents are actively involved with the team in the IEP development	94%	100%
The use of direct and/or indirect treatment is based solely on the needs of each student	76%	94%

Pre-Post Rating of Competencies

An unexpected finding from the program was that the majority of therapists did not perceive the self-assessment process based on competencies as a resource. From subjective feedback, it appears that this was related to the time commitment needed for truly reflecting on the competencies, documenting how competencies were achieved, and developing an action plan to address areas of learning needs. Unfortunately it was not possible to make an exact comparison between pre- and post program rating of achievement of competencies for therapists practicing in educational or early intervention settings for two reasons. Firstly, some students early in the program completed a draft version of the competency document as their pre-assessment and the final version had been revised. Secondly, some students did not complete their pre-assessment to sometime into the program and indicated that the first course they attended had impacted their ratings. What follows is a summary of the trends that were noted between the pre- and post assessments.

At pre-assessment the therapists rated themselves on the competencies from a 1 (no experience) to a 4 (achieved). However, the ratings were predominately 2s (minimal competence) and 3s (emerging competence). On the pre-assessments there were more 1s (no experience) then on the post assessments and ratings of 4 (achieved) were rarely indicated. At both pre- and post assessments the competency category areas that were scored the lowest were prevention, administration, and research. At pre-assessment therapists indicated limited knowledge and skills related to community resources, legislation, documentation, family issues, and collaboration and these areas were subsequently addressed through coursework, especially their practicum with a mentor. The therapists in the school-based program also indicated limited knowledge of education curriculums and a true understanding of the role of the therapist in a school setting. At post assessment the therapists rated themselves on the competencies from a 1 (no experience) to a 4 (achieved). However, the ratings were predominately 3s (emerging competence) and 4s (achieved). On the post assessments, ratings of 1 (no experience) were

rarely noted and for the majority of therapists ratings of 4s (achieved) were predominantly seen especially in the competency category areas of context of practice / role of therapist, examination, planning, intervention, and documentation.

Development of a Professional Portfolio

As a culminating experience all therapists who completed the certificate program developed a professional portfolio to reflect their professional accomplishments and achievement of the competencies. These portfolios were evaluated at the end to determine the program impact on the individual therapist. In the portfolios therapists included a variety of artifacts including: their professional curriculum vitae, performance appraisal evaluations from their employer, course assignments and projects, a journal describing their post professional education experience, a reflection paper that synthesized the knowledge and skills they gained as well as shared their insights on how the experience impacted their clinical practice, handouts from professional inservices that they presented to colleagues, and notes and cards they received from families that they served. Overall the therapists indicated that the process of developing a portfolio was beneficial to their professional development. It helped them to synthesize and integrate the knowledge and skills they gained from the certificate program with their professional practice, highlighted their strengths, and provided them direction for future professional growth.

Student Accomplishments:

In addition to obtaining their certificate, several professional accomplishments were note worthy. One student received her specialty certification in pediatrics from American Occupational Therapy Association, seven students matriculated into a graduate degree program, and two students presented posters at a professional conference. The following student publications resulted from the certificate program:

Costello C. Inclusion and universal design on the playground. Pennsylvania Recreation and Parks, 2nd quarter 2000, 14-16

Muhlenhaupt M. OT services under IDEA 97: Decision making challenges. OT Practice, December 4 & 18, 2000, 10-13.

Muhlenhaupt M. Family and school partnerships for IEP development. Submitted for publication to the Journal of Visual Impairment and Blindness.

Szabo JL. Maddie's story: Inclusion through physical and occupational therapy. Teaching Exceptional Children, Nov/Dec 2000, 12-18.

Szabo JL. School-based physical therapy: What you need to know to get started. Parts 1 and 2. Advance for Physical Therapists & PT Assistants, May, 7 & 21, 2001.

MCP Hahnemann University
Department of Rehabilitation Sciences
Programs in Pediatric Physical Therapy

SPECIALTY CERTIFICATE PROGRAM FOR PHYSICAL AND OCCUPATIONAL THERAPISTS IN SCHOOL-BASED SERVICES

Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area A **The context of therapy in early intervention settings**			
1. *Knowledge of the structure, global goals, and responsibilities of the public education system, including special education *a) diagram the functional and supervisory organization of the education system served by the therapist* *b) identify the goals and outcomes of the educational curriculum from preschool through high school* *c) demonstrate an understanding of the eventual goals of independent living and working* *d) apply knowledge of the outcomes-based education curriculum*	1 2 3 4		
2. *Knowledge of federal (for example IDEA, Rehabilitation Act of 1973, & ADA), state, and local laws and regulations that affect the delivery of services to students with disabilities *a) discuss the implications of the laws (national, state and local)* *b) apply the guidelines of federal, state, and local regulations* *c) identify and use information sources for federal, state, and local legislation and regulation changes* *d) discuss and demonstrate professional behavior regarding ethical and legal responsibilities* *e) discuss professional competencies as defined by professional organizations and state regulations* *f) advocate to support services related to educational entitlements*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
3. Knowledge of the theoretical and functional orientation of a variety of professionals serving students within the educational system *a) initiate dialogue with colleagues to exchange professional perspectives* *b) disseminate information about the availability of therapy services, criteria for eligibility, and methods of referral* *c) describe evaluations and interventions commonly used by psychologists, diagnostic educators, classroom teachers, speech and language pathologist, adaptive physical educators, nurses, physical therapists, occupational therapists, and professionals in other education and health-related disciplines*	1 2 3 4		
4. *Assist students in accessing community organizations, resources and activities *a) demonstrate awareness of cultural and social differences that relate to family and student participation in the education program* *b) in collaboration with the educational team, develop a plan for transition into community activities or adult services* *c) identify the need to make appropriate student referrals to community therapy and recreational services when school services are not able to meet all of the child's needs* *d) include the family in the educational process* *e) serve as a resource to family and other team members for information and appropriate community resources (medical, educational, financial, social, recreational, and legal)*	1 2 3- 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area B **Wellness and prevention in early intervention settings**			
1. Implement school wide screening program with school nurse, physical education teacher, and teachers *a) apply knowledge of risk factors affecting growth, development, and learning* *b) identify the etiology, signs, symptoms, and classifications of common pediatric disabilities* *c) identify established biological and environmental factors that affect children's development and learning* *d) select, administer, and interpret a variety of screening instruments and standardized measurement tools*	1 2 3 4		
2. Promote child safety and wellness using knowledge of environmental safety measures *a) maintain CPR certification* *b) institute an environmental hazards and accident prevention plan* *c) recognition of child neglect and abuse*	1 2 3 4		
Content Area C **Roles of a therapist in education settings**			
1. *Form partnerships and work collaboratively with other team members, especially the teacher to promote an effective plan of care *a. demonstrate effective communication and interpersonal skills* *b. refer and coordinate services among family, school professionals, medical service providers, and community agencies* *c. implement strategies for team development and management* *d. develop mechanism for ongoing team coordination*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
2. *Function as a consultant *a) identify the administrative and interpersonal factors that influence the effectiveness of a consultant* *b) implement effective consultative strategies* *c) provide technical assistance to other school team members, community agencies, and medical providers*	1 2 3 4		
3. *Educate school personnel and family to promote the inclusion of the student within the educational experience *a) assist school administrators with development of policy and procedures* *b) provide orientation to teachers and classroom aides* *c) conduct inservice sessions* *d) develop informational resources*	1 2 3 4		
4. Supervise personnel and professional students *a) apply effective strategies of supervision* *b) monitor the implementation of therapy recommendations by other team members* *c) establish a student clinical affiliation* *d) formally and informally teach / train therapy staff*	1 2 3 4		
5. *Serve as an advocate for students, families, and school *a) attend public hearings* *b) serve on task force or decision making committees* *c) provide necessary information to support student rights* *d) actively participate in IEP process*	1 2 3 4		
Content Area D **Examination and Evaluation in education settings**			
1. *Identify strengths and needs of student *a) interview student, family, teachers, and other relevant school personnel* *b) gather information from medical personnel and records* *c) observe student in a variety of educational settings*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
2. *Collaboratively determine examination and evaluation process *a) designate appropriate professional disciplines* *b) identify environments and student activities and routines* *c) select instruments* *d) establish format for conducting examination* *e) inform and prepare the student*	1 2 3 4		
3. *Determine student's ability to participate in meaningful school activities by examining and evaluating: *a) conduct formal naturalistic observations to determine level of participation and necessary assistance / adaptations* b) *functional abilities including: gross motor, fine motor, perceptual motor, cognitive, social/emotional, and ADLs* *c) impairments related to functional ability including: musculoskeletal status, neuromotor organization, sensory function, and cardiopulmonarystatus*	1 2 3 4		
4. *Utilize valid, reliable, cost-effective, and nondiscriminatory instruments for: *a) identification and eligibility* *b) diagnostic purposes* *c) individual program planning* *d) documentation of progress*	1 2 3 4		
Content Area E **Planning**			
1. *Actively participate in the development of the Individualized Education Plan *a) determine eligibility related to a student's educational program* *b) accurately interpret and communicate examination findings collaboratively with family, student, and other team members*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
c) discuss prognosis of student performance related to curricular expectations *d) discuss and prioritize outcomes related to student's educational needs based on current / future environmental demands and student / family preferences and goals* *e) offer appropriate recommendations for student placement and personnel needs in the least restrictive educational setting with intent to serve children in inclusive environments* *f) in collaboration with the team, determine how therapy can contribute to the development of an individualized educational program (IEP) including:* *i. meaningful student outcomes* *ii. functional and measurable goals and objectives* *iii. therapy service recommendations* *iv. specific intervention methods / strategies* *v. determination of frequency, intensity, and duration* *g) develop mechanism for ongoing coordination and collaboration regarding the IEP* *i. implementation of the IEP* *ii. update or modify IEP* *iii. transition planning & implementation of the transition plan* *iv. interagency activities*			

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area F **Intervention**			
1. •Adapt environments to facilitate student access to and participation in student activities *a) recommend adaptive equipment, assistive technology, and environmental adaptations* *b) monitor adaptive equipment, assistive technology, and environmental adaptations* *c) be able to instruct student and other team members in the appropriate use of adaptive equipment and / or assistive technology* d) *identify sources for obtaining, maintaining, repairing, and financing adaptive equipment, assistive technology, and environmental adaptations*	1 2 3 4		
2. •Use various types and methods of service provision for individualized student interventions: *a) direct, individual, group, integrated, consultative, monitoring, and collaborative approaches* *b) develop generic instruction plans and intervention plans that select and sequence strategies to meet the objectives listed on the student's IEP*	1 2 3 4		
3. •Promote skill acquisition, fluency, and generalization to enhance overall development, learning, and student participation *a) use creative problem-solving strategies to meet the student's needs* *b) explain the basic motor learning theories, and relate them to therapy education programs* *c) address neuromuscular, musculoskeletal, sensory processing, and cardiopulmonary functions that support motor, social, emotional, cognitive, and language skills*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
4. •Imbed therapy interventions into the context of student activities and routines *a) implement appropriate positioning, mobility, environmental, and ADL strategies into curriculum, classroom schedule and routines* *b) develop a matrix integrating objectives, routines / activities, and strategies*	1 2 3 4		
Content Area C **Documentation**			
1. Produce useful written documentation by: *a) writing reports in commonly understood and meaningful terms* *b) maintaining timely and consistent records* *c) concisely summarizing relevant information* *d) sharing records with family and other team members*	1 2 3 4		
2. •Collaboratively monitor and modify student's IEP *a) establish a mechanism for and record ongoing communication with family and other team members* *b) establish a plan of action for re-evaluation* *c) schedule pre-established team meetings to review student progress over the course of the school year*	1 2 3 4		
3. •Evaluate and document the effectiveness of therapy education programs *a) Establish baseline of student's level of participation and functional status* *b) collect ongoing data on the student's progress toward stated IEP outcomes* *c) summarize data to determine student's progress*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area H **Administrative issues in education settings**			
1. Demonstrate flexibility, priority setting, and effective time management strategies	1 2 3 4		
2. Obtain resources and data necessary to justify establishing a new therapy program or altering an existing program	1 2 3 4		
3. Serve as a leader *a) integrate knowledge of education, health, and social trends that impact therapy services* *b) identify and educate others on the overall roles, responsibilities, and functions of therapy services* *c) identify and differentiate characteristics of alternative approaches for resolving needs of therapy services* *d) identify the administrative needs of the therapy service within the educational setting* *3. serve as a role model to other therapists regarding professional responsibilities*	1 2 3 4		
4. Serve as a manager *a) develop and analyze job descriptions for therapists* *b) implement a recruitment, orientation, mentorship, and professional development program for therapists and staff* *c) develop and implement policies and procedures to guide therapy services* *d) establish therapy caseloads and staffing needs* *e) evaluate the performance of therapy personnel* *f) plan and implement a therapy quality assurance plan and program evaluation* *g) participate in the assessment of school facilities and educational activities* *h) makes recommendations, especially related to ensuring accessibility and reasonable accommodations to school environments* *i) identify and use appropriate school, home, community, state, and national resources, especially funding sources*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
j) demonstrate the ability to plan and manage a budget for the therapy component of services			
Content Area I **Research**			
1. *Demonstrate knowledge of current research relating to child development, medical care, educational practices, and implications for therapy *a) conduct a literature review* *b) seek assistance for experienced researchers in interpreting published research* *c) critically evaluate published research*	1 2 3 4		
2. *Apply knowledge of research to the selection of therapy intervention strategies, service delivery systems, and therapeutic procedures *a) use objective criteria for evaluation* *b) justify rationale for clinical decision making* *c) expand clinical treatment cases into single-subject studies*	1 2 3 4		
3. Partake in program evaluation and clinical research activities with the appropriate supervision *a) identify research topics* *b) secure resources to support clinical research* *c) implement clinical research projects* *d) disseminate research findings*	1 2 3 4		
Content Area J **Professional Development**			
1. Utilize opportunities and resources available to enhance professional knowledge, skills, and attitudes	1 2 3 4		
2. Attend study groups, conferences, workshops, and continuing education courses	1 2 3 4		
3. Serve on committees, advisory boards, work groups and task forces	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
4. Present at inservices, conferences, workshop, and courses	1 2 3 4		
5. Publish on current issues	1 2 3 4		
6. Enroll in post professional certificate or degree programs	1 2 3 4		

This document provides a comprehensive list of professional competencies for therapists in school-based settings. The competencies that are noted with an * are specifically addressed in MCP Hahnemann University, Department of Rehabilitation Sciences, Specialty Certificate Program. This document can assist you in your overall professional development.

Self Rating Scale:
1= No experience
2= Minimal competence
3= Emerging competence
4= Achieved

Action Plan: Steps to taken and resources to accessed in order to achieve competency. May include: plans to take a course, a specific course assignment, a job-related activity, in-services and other continuing education, literature analysis, consulting with an expert in the area, shadowing an expert, etc.

Evidence of Accomplishment: Objective documentation that demonstrates achievement of the competency. This may include: actual client reports (i.e. IEP documents), videotaped interviews or treatment sessions, handouts prepared for a presentation, written assignments/papers, etc. This documentation should be included in your student portfolio.

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MCP Hahnemann University
Department of Rehabilitation Sciences
Programs in Pediatric Physical Therapy

SPECIALTY CERTIFICATE PROGRAM IN EARLY INTERVENTION

Content Area Competency *Indicator*	**Self Rating**	**Action Plan**	**Evidence for Achievement**
Content Area A **The context of therapy in early intervention settings**			
1. *Knowledge of local, state and federal laws, rules and regulations regarding service delivery *a) discuss the implications of PL 94-142, PL 99-457, and PL 105-17 and their reauthorizations* *b) apply the guidelines of federal, state and local regulations* *c) identify and use information sources for federal, state, and local legislation and regulation changes* *d) discuss and demonstrate professional behavior regarding ethical and legal responsibilities* *e) discuss professional competencies as defined by professional organizations and state regulations* *f) advocate to support family and child entitlements*	1 2 3 4		
2. *Knowledge of the central importance of family and is able to provide family-centered services *a) conduct a family interview using active listening skills to gather information on: family's knowledge, strengths, concerns, and priorities regarding their* *i. child* *ii. family lifestyle and beliefs* *iii. services and outcomes desired* *b) respect the family and acknowledge that the family is the most significant member of the team* *c) recognize that children are best understood in the contexts of family, culture, and community*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
3. Knowledge of family systems theory and its application to practice *a) Identify and discuss how the following factors may affect a child's and family's experience with an early intervention program:* *i. cultural* *ii. socioeconomic* *iii. ethical* *iv. historical* *v. personal values*	1 2 3 4		
4. *Recognize the impact of a child with special needs on a family unit throughout the family life cycle *a) describe a typical daily routine and activities that families may encounter* *b) implement basic strategies to support the family unit, including the parents, parent-child relationships, and sibling subsystems*	1 2 3 4		
5. *Support the parents' primary roles as mother and father to the child *a) assist the family in identifying and developing:* *i. internal and external resources* *ii. a social support network* *iii. advocacy skills* *b) advocate the right of parents to be decision makers in the early intervention process* *c) provide parents with the information and options needed for informed decisions* *d) respect parents' choices and goals for their children*	1 2 3 4		
6. *Collaborate and encourage family involvement with the early intervention process *a) implement, a range of family-oriented services based on the family's identified resources, priorities, and concerns* *b) provide information on family oriented conferences and support groups in the community* *c) demonstrate people first and family friendly communication and interaction skills* *d) communicate effectively with parents about curriculum and child's progress*	1 2 3 4		

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Content Area Competency *Indicator*	**Self Rating**	**Action Plan**	**Evidence for Achievement**
Content Area B **Wellness and prevention in early intervention settings**			
1. Promote public awareness of early intervention services *a) disseminate information about the availability, criteria for eligibility, and methods of referral* *b) collect and use data from multiple sources for child-find systems*	1 2 3 4		
2. Design and implement a screening program to identify infants and toddlers at risk for developmental delay *a) demonstrate knowledge of genetic and cultural differences in standards of growth and development* *b) identify the etiology, signs & symptoms, and classifications of common pediatric disabilities* *c) identify established biological and environmental factors that affect children's development and learning* d) *demonstrate understanding of developmental consequences of maternal health & nutrition, social supports, and stress*	1 2 3 4		
3. *Select, administer, and interpret a variety of screening instruments and standardized measurement tools *Apply knowledge of:* *a) child development from cognitive, adaptive, motor, social-emotional, and communication perspectives* *b) the interrelationship among developmental areas* *c) the range of normal variations of development* *d) the difference between delayed and atypical development*	1 2 3 4		
4. Promote child safety by educating caregivers on: *a) child development* *b) environmental and toy hazards and safety measures* *c) accident prevention* *d) recognition of child neglect and abuse*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area C **Coordinated care in early intervention settings**			
1. *Form a partnership and work collaboratively with other team members, especially the child's family *a) refer and coordinate services among family, other professionals, community agencies, day care programs* *b) demonstrate effective and appropriate interpersonal communication skills* *c) implement strategies for team development and management* *d) develop mechanism for ongoing team coordination* *e) function as an interdisciplinary or transdisciplinary team member* *f) if applicable, serve as a service coordinator*	1 2 3 4		
2. Function as a consultant *a) identify the administrative and interpersonal factors that influence the effectiveness of a consultant* *b) provide technical assistance to other early intervention team members, community agencies, and medical facilities*	1 2 3 4		
3. Supervise personnel and professional students *a) monitor the implementation of therapy recommendations by other team members* *b) establish a student clinical affiliation* *c) formally and informally teach/train therapy staff*	1 2 3 4		
Content Area D **Examination and evaluation in the early intervention setting**			
1. *Individualize the examination and evaluation for child, team, and family needs. *a) offer flexible scheduling* *b) provide options for multiple settings* *c) solicit input on the process* *d) establish consensus of content including domains of child development and family routines*	1 2 3 4		

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Content Area Competency *Indicator*	**Self Rating**	**Action Plan**	**Evidence for Achievement**
2. •Evaluate family strengths, resources, concerns, and priorities *a) conduct family interview* *b) select and administersupplemental family surveys*	1 2 3 4		
3. Selectively gather, interpret, and report information from available medical/developmental records	1 2 3 4		
4. •Examine and evaluate child abilities and strengths: *a) functional ability including activities of daily living, play, and gross motor, fine motor, perceptual motor, and oral motor skills,* *b) musculoskeletal status* *c) neuromotor status* *d) sensory status* *e) cardiopulmonary status*	1 2 3 4		
5. •Utilize valid, reliable, and nondiscriminatory examination instruments and procedures for: *a) identification & eligibility* *b) diagnostic evaluation* *c) individual program planning* *d) documentation of child progress, family outcomes, and program impact*	1 2 3 4		
6. Function as a team leader and/or member in a multidisciplinary, interdisciplinary, or transdisciplinary assessment *a) organization* *b) time management* *c) timeliness* *d) constructive feedback* *e) consensus building* *f) wrap-up*	1 2 3 4		
Content Area E **Planning**			
1. •Actively participate in the development of the Individualized Family Service Plan: *a) accurately interpret and communicate examination findings to the family and other team members* *b) discuss and integrate examination findings from family and other team members* *c) solicit from family their goals of the early intervention process*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
d) Prioritize needs identified during examination according to: *i. family preference and goals* *ii. environmental demand* *iii. future environmental demands* *iv. resources* *v. developmental level* *vi. past history* *e) collaboratively establish IFSP outcomes that are meaningful to the child and family* *f) communicate options for strategies, programs and services to family* *g) establish consensus on strategies, programs and services*			
2. •Integrate an interdisciplinary understanding of the home, child care, medical and social community of the child and family into the IFSP: *a) inquire about family routines and activities* *b) establish contact and with permission consult with day care / preschool providers* *c) establish collaborative relationship with any relevant medical personnel* *d) inquire about community resources from local interagency coordinating council* *e) gather with family information on community activities, programs, services, and resources*	1 2 3 4		
3. •Develop mechanism for ongoing coordination and collaboration regarding the IFSP *a) implementation of the IFSP* *b) update or modify IFSP* *c) transition planning & implementation of the transition plan* *d) interagency activities*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area F **Intervention**			
1. *Develop and implement appropriate intervention programs and strategies that address or incorporate: *a) self-care, mobility, learning and play* *b) values of the family and child's culture* *c) developmentally and individually appropriate activities* *d) environmental adaptations in the home and community* *e) information and strategies from multiple disciplines* *f) medical care of infants and toddlers* *g) methods of behavior support and management*	1 2 3 4		
2. *Assist families in accessing services that promote full inclusion of child and family into the community *a) provide services in the child's natural environments* *b) communicate with, and educate, family/caregivers, teachers, and others regarding intervention strategies* *c) implement small group parent-child and peer activities when appropriate for a particular community setting* *d) link current intervention plan with the next educational setting*	1 2 3 4		
3. *Integrate therapy intervention strategies into home and community settings: *a) support and facilitate family child interaction as primary context for learning and development* *b) utilize daily routines including child care activities such as feeding, bathing, dressing, and playing* *c) utilize parent and child mediated activities during intervention* *d) modify intervention strategies according to changes in the child's interests, functional level, medical status, or family needs*	1 2 3 4		
Content Area G **Documentation issues in early intervention settings**			
1. Produce useful written documentation by: *a) utilizing commonly understood and meaningful terms* *b) maintaining timely and consistent records* *c) concisely summarizing relevant information* *d) sharing records with family and other team members*	1 2 3 4		

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Content Area Competency *Indicator*	**Self Rating**	**Action Plan**	**Evidence for Achievement**
2. •Demonstrate the ability to write the IFSP document, including: *a) current developmental and functional status of the child* *b) long-and short-term child and family objectives that are meaningful, functional and measurable* *c) objective means of monitoring progress* *d) description of the early intervention and community services* *e) justification for frequency, intensity, location, & service delivery*	1 2 3 4		
3. Document to convey information to family, other team members, and funding agencies including: *a) summary of intervention session* *b) child' s response* *c) ideas for daily activities and routines* *d) plans for new intervention strategies and resources*	1 2 3 4		
4. •Collaboratively monitor and modify child's intervention plan *a) establish a mechanism for ongoing communication with family and other team members* *b) record summary of communications with family and other team members* *c) establish a plan for re-evaluation* *d) schedule pre-established team meetings to review child's progress*	1 2 3 4		
5. •Evaluate and document the effectiveness of therapy intervention strategies and therapeutic procedures *a) establish baseline of child's developmental and functional status* *b) collect ongoing data on the child's progress toward stated IFSP outcomes* *c) summarize data to determine child's progress* *d) make recommendations for modifications of IFSP*	1 2 3 4		

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Content Area Competency *Indicator*	Self Rating	Action Plan	Evidence for Achievement
Content Area H **Administration issues in early intervention settings**			
1. Function as an administrator: *a) identify the philosophy, goals, structure and function, and administrative needs of the early intervention program and therapy services* *b) apply knowledge of other disciplines' roles and functions for program planning and policy formation* *c) develop and implement criteria and procedures for job descriptions, recruitment, staff selection, supervision, and performance appraisals* *d) develop therapy policies and procedures* *e) direct therapy services and delegate appropriate responsibilities* *f) establish appropriate and manageable caseloads* *g) meet deadlines in order to be able to provide services in a timely and efficient manner* *h) identify and develop appropriate referral mechanisms* *i) develop procedures for documenting service in accordance with Codes of Ethics, funding agency policies, and federal, state, and local regulations*	1 2 3 4		
2. Demonstrate the ability to assist and support the professional development of early intervention personnel *a) identify and access intramural and extramural funding sources and resources* *i. community* *ii. state* *iii. national* *b) provide onsite inservice training* *c) establish intra-agency mentoring program* *d) implement individualized professional development plan*	1 2 3 4		
3. Demonstrate leadership abilities in promoting effective team processes *a) facilitate regularly scheduled staff meetings* *b) implement mentor program* *c) provide opportunity for staff inservices* *d) selectively delegate responsibilities* *e) allocate time for team collaboration* *f) mediate team differences*	1 2 3 4		

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Content Area Competency *Indicator*	**Self Rating**	**Action Plan**	**Evidence for Achievement**
Content Area I **Research in early intervention settings**			
1. •Demonstrate knowledge of current research relating to infant development, medical care, and developmental intervention for infants, and toddlers *a) conduct a literature review using such reference materials as Index Medicus, or other data base sources* *b) seek assistance from experienced researchers in interpreting published research* *c) critically evaluate published research*	1 2 3 4		
2. •Apply knowledge of research to the selection of therapy intervention strategies, service delivery systems, and therapeutic procedures in early intervention *a) use objective criteria for evaluation* *b) justify rationale for clinical decision making* *c) expand clinical treatment cases into single-subject studies*	1 2 3 4		
3. Partake in program evaluation and clinical research activities with the appropriate supervision *a) identify topics in early intervention in which research efforts are needed* *b) secure resources to support clinical research* *c) implement clinical research projects* *d) disseminate research findings*	1 2 3 4		
Content Area J **Professional Development**			
1. Utilize opportunities and resources available to enhance professional knowledge, skills, and attitudes	1 2 3 4		
2. Attend study groups, conferences, workshops, and continuing education courses	1 2 3 4		
3. Serve on committees, advisory boards, work groups and task forces	1 2 3 4		
4. Present at inservices, conferences, workshops, and courses	1 2 3 4		
5. Publish on current issues	1 2 3 4		
6. Enroll in post professional certification or degree programs	1 2 3 4		

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Self Rating Scale for Competencies: Review the suggested behavioral indicators associated with each competency to determine your individual level of achievement.

1 = No experience
2 = Minimal competence
3 = Emerging competence
4 = Achieved

Action Plan: Steps to be taken and resources to be accessed in order to achieve competency. May include: plans to take a course, a specific course assignment, a job-related activity, inservices and other continuing education, literature analysis, consulting with an expert in the area, shadowing an expert in the area, etc.

Evidence of Achievement: Objective documentation which demonstrates that you have achieved the competency. This may include: actual client reports (ie. IFSP documents), videotapes of family interview or intervention, handouts from a presentation that you developed, written assignments/papers, etc. This documentation should be included in your student portfolio.

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